FLORIDA DEPARTMENT OF JUVENILE JUSTICE

SAMPLE

INITIAL MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT PLAN

Youth's Name_____

DOB_____ Sex_____ Race_____ JJIS No. _____

Facility Name _____Circuit _____

1. Reason for Mental Health/Substance Abuse Treatment:

_____

_____

_____

2. Initial Diagnostic Impression or Presenting Symptoms:

Initial DSM-IV-TR or DSM-5 Diagnoses				
DSM-IV-TR Diagnoses				
Axis I	Axis II	Axis III	Axis IV	Axis V (GAF)
DSM-5 Diagnoses				
Presenting Symptoms				

3. Initial Treatment Methods: (Describe treatment methods, duration, amount and frequency of mental health and/or substance abuse services. For youths receiving psychiatric care, record: 1. Psychotropic medications currently prescribed; and 2. Frequency of monitoring by a psychiatrist).

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_____

_____

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_____

_____

4. Initial Treatment Goals and Objectives-

Goal:
Objective:
Goal:
Objective:
Goal:
Objective:

_____ _____

Youth's Signature/Date Parent/Guardian's Signature/Date

_____ _____

Mental Health/Substance Abuse Clinical Staff' Signature/Date Treatment Team Member Signature/Date

_____ _____

Licensed Mental Health Professional's or CAP Signature/Date Treatment Team Member Signature/Date